Prescribers and Pharmaceutical Representatives: Why Are We Still Meeting?

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CONTEXT: Research suggests that pharmaceutical marketing influences prescribing and may cause cognitive dissonance for prescribers. This work has primarily been with physicians and physician–trainees. Questions remain regarding why prescribers continue to meet with pharmaceutical representatives (PRs).

OBJECTIVE: To describe the reasons that prescribers from various health professions continue to interact with PRs despite growing evidence of the influence of these interactions.

DESIGN, SETTING, AND PARTICIPANTS: Multidisciplinary focus groups with 61 participants held in practice settings and at society meetings.

RESULTS: Most prescribers participating in our focus groups believe that overall PR interactions are beneficial to patient care and practice health. They either trust the information from PRs or feel that they are equipped to evaluate it independently. Despite acknowledgement of study findings to the contrary, prescribers state that they are able to effectively manage PR interactions such that their own prescribing is not adversely impacted. Prescribers describe few specific strategies or policies for these interactions, and report that policies are not consistently implemented with all members of a clinic or institution. Some prescribers perceive an inherent contradiction between academic centers and national societies receiving money from pharmaceutical companies, and then recommending restriction at the level of the individual prescriber. Prescribers with different training backgrounds present a few novel reasons for these meetings.

CONCLUSIONS: Despite evidence that PR detailing influences prescribing, providers from several health professions continue to believe that PR interactions improve patient care, and that they can adequately evaluate and filter information presented to them by PRs. Focus group comments suggest that cultural change is necessary to break the norms that exist in many settings. Applying policies consistently, considering non-physician members of the healthcare team, working with trainees, restructuring the current primary care model and offering convenient, individualized, non-biased educational options may aid success.

KEY WORDS: pharmaceutical marketing; prescriber behavior; policy; training.
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INTRODUCTION

Studies show that marketing strategies used by pharmaceutical representatives (PRs) such as education, samples, office support, and patient resources can increase brand recognition and influence prescribing.[1–11] Recent headlines question pharmaceutical marketing techniques, presentation of data regarding side effects and clinical impact in the lay press and peer reviewed medical journals.[12–21] Despite this evidence prescribers continue to accept gifts and other support from PRs and companies and to believe that they are immune to their influence.[5,22–29] In response, national organizations, medical societies, politicians and academic medical centers are responding with increasingly stringent recommendations governing trainee and clinician interactions with PRs.[6,30–39] Earlier work suggests that physicians may be aware of some of the conflicts that arise through accepting gifts from PRs, and employ common defense mechanisms to deal with this cognitive dissonance.[23] While this may explain how they rationalize these visits, it does not explain why they continue. Little work addresses other licensed prescribers.[11,29,40–41]

It is clear that effective medical practice requires appropriate use of pharmaceutical products. How to use interactions between the pharmaceutical industry (pharma) and prescribers to maximize patient benefit remains elusive. Two prior qualitative studies investigated aspects of physician's relationships with PRs. One interviewed general practitioners (GPs) in the United Kingdom (UK); however, differences between the UK and United States (US) healthcare systems question whether those findings would be relevant to US prescribers.[42] The other attempted to explain the inconsistencies in physicians' behavior with PRs, but did not explore the reasons for these

interactions.[23] Neither study offered specific recommendations for change. Information regarding attitudes and characteristics of interactions with non-physician prescribers (physicians, advanced practice nurses, physician assistants) is limited. Such information may help inform and implement policy. This paper describes the findings of focus groups with prescribers of varied training using a qualitative analytic approach.

METHODS

We held 11 focus groups with a total of 61 prescribers (NP, PA, PharmD, MD) between November 2006 and March 2007. Focus groups met in outpatient practice settings, and regional and national meetings in Massachusetts, New Hampshire, Vermont and New Mexico. Settings were selected to represent diversity of prescribers by training, types of practice and geographic location and included University of Massachusetts (UMMS) Community Medical Group, Lovelace Medical Group, and Dartmouth-Hitchcock Medical Center-affiliated community practitioners, and attendees at the UMMS Community Faculty Development Center Teachers of Tomorrow (TOT) educational conference, Nurse Practitioner Associates for Continuing Education (NPACE) and Physician Assistant Academy of Vermont (PAAV) annual conferences. Participants came from more than nine states, and were solicited via standardized email invitation to participating group practice distribution and meeting registration lists. Community-based practitioners received an email invitation from group-affiliated administrators. Conference attendees received an email invitation from conference organizers. Those interested contacted the research group/conference organizers directly. Generalist and primary care prescribers were targeted, though some prescribers had worked in subspecialty fields in the past, or held combined positions. The study was approved by the IRBs of Dartmouth-Hitchcock Medical Center, the Lovelace Clinic Foundation and the University of Massachusetts Medical School.

Guided by a review of the literature focus group questions were drafted and pilot tested by the authors together with a group of prescribers (n = 5). A final version of questions and script was developed (Appendix). Two authors (MF, MEK) conducted the focus groups. Participants completed a one-page demographic survey prior to the 50–90 minute focus groups. Focus groups were audiotaped and transcribed. An initial coding key was developed based on review of the medical literature and the study questions, and refined by all authors based on independent review of focus group transcripts. Codes were developed to identify themes that would provide insight into the factors that explained or reinforced prescribers' acceptance of PRs. Three authors (MEK, LS, MF) were trained in coding using a single transcript. MEK and LS both coded all transcripts independently with discussion of variation, MF provided resolution of any remaining discrepancies. Findings are presented by theme with emphasis on new topics or further detail for those previously described. Paired recommendations follow.

RESULTS

Focus group participants were 56% MD, 62% female and 48% practiced in primary care internal medicine. Approximately one-third identified with an academic and another one-third with community-based practices (Table 1).

Perceptions of PR Interactions and Information

Overall PR interactions were perceived as beneficial by most participants. Nearly all participants expressed or agreed with statements such as "the positives of having them are far greater [than the negatives]," or "…we are quite accepting of the pharmaceutical reps. We've only had positive experiences… I think drug reps are pretty honest…"

Focus group members expressed a pervasive belief that prescribing is not adversely influenced by PR detailing, despite acknowledgement of studies to the contrary. Though some focus group discussants questioned the validity of some PR data, they felt they were able to sift through the marketing pitch to glean useful information. For example "you just have to learn that you can't expect them to be totally objective… Pharm reps exist across the country, because they do influence our behavior. So in a way, just being aware, like any form of advertising, it will influence your behavior and you try to be conscious of that."

Participants commented that they could ask PRs for specific data and assess the findings themselves. A few worked specifically with Clinical Education Consultants (CECs), usually PharmDs who do not detail, but are hired by the

Table 1. Demographics

Profession	N (%)
MD	34 (56)
PA	10 (16)
NP	16 (26)
Pharm D	1 (02)
Gender	
Male	23 (38)
Female	38 (62)
Practice area	
Primary care	43 (71)
Subspecialist	13 (21)
Specialty area	
Internal medicine	29 (48)
Family medicine	17 (28)
Pediatric medicine	2 (03)
Geriatric medicine	3 (05)
Other	8 (13)
Practice setting	
Academic affiliation	21 (34)
Community-based practice	24 (39)
Academic affiliation and community-based practice	8 (13)
Other *(details below)*	8 (13)
Hospitalist (including ER)	5
VA Hospital	1
Multispecialty group	1
Research and development	1
Pharmaceutical representatives have access to prescriber	
Yes	47 (77)
No	14 (23)
	Mean (Range)
Age	47(29–65)
Years prescribing medication	15 (1–32)
Years in practice in current profession	15 (1–32)
Average number of PR interactions monthly	9 (0–80)

N = 61

pharmaceutical company to provide more specific information regarding drug evaluation and even off-label prescribing. Some felt conflicted, as one participant said "Everybody individually thinks well I'm glad somebody else is being influenced by them and I'm not. But we know that it works…so I do think it is important to find some way to educate the medical students and the house staff about it."

Some focus group participants also reported discomfort with or dislike of the actual meetings or paradoxically said "My rule is I [listen but] don't believe anything they're saying." Some offered justification such as following the custom of their practice group or the perceived need for PR give-aways. Others voiced discomfort with PR behaviors that reached beyond clinical settings such as funding for social events and travel to meetings.

Recommendations. While some argue that complete injunction on PR detailing is the only solution, the current interrelationship between the US healthcare system and pharma make this challenging and possibly unrealistic to implement outside of academic medical centers. An initial strategy might focus on teaching trainees and prescribers how to take control of these interactions with the goal of maximizing the benefit to both prescribers and patients while minimizing the negative impact of marketing. Studies supporting the role of educational interventions have shown that specific curricula can influence trainee behavior regarding interactions with PRs.[43–47] Specific skills for evaluating promotional literature could be integrated into evidence-based medicine curricula.[48] Communication skills such as dealing with influence and assertiveness could be helpful to prescribers in working with PRs and could improve patient communication.[49] Providing this education for licensed providers may be challenging as most clinicians don't think they need it, though they believe more junior members might benefit.[50] This fact might be used to gain buy-in for licensed prescriber training. Mandated continuing education in this area, similar to mandated credits in risk management in some states, may help to ensure compliance. Dedicated studies should assess these areas.

Benefits of Meetings to Prescribers

Focus group participants of all training backgrounds reported that they benefited from easy access to information about new and old drugs through interactions with PRs. They made statements such as "they help because of the information, the ability to get questions answered, and samples are a big help, especially with indigent populations." "I see every rep that comes into the office…I see 25 reps a month. And I get a lot of information from the reps; the basics." "I do like to know about a drug before it hits the community."

Timeliness and convenience of PR meetings were appealing, and some participants, particularly community-based, reported enjoying the social aspects of PR interactions. One relayed an incident where "they stopped allowing reps in my office, and this one had information for me, so I told her she could join me for a run. She went not only the extra mile, but an extra 2 miles and talked to me about the product the whole way. That was really helpful. You bet I still see her any time she wants to see me."

Participants opined that primary care office budgets are tight, and the supplies and food that PRs brought contributed to smooth functioning of the office. A sample comment was "I work in non-profit…you know [reps] do provide me with pens… [and] somehow my administrator doesn't want to spend too much money on office supplies." Some commented that office lunches were a perk anticipated by the entire staff, which helped them to retain employees. Others talked about the personal, social need that off-site meetings fill, "Going out to dinner as a group….That's why we do it, more of a social setting outside of the wards."

Recommendations. When pressed as to how PR interactions might be replaced, focus group participants reported they want unbiased, evidence-based CD or online resources, or independent pharmacists available to address prescribing questions. They recommended programs to which they could pose specific questions, and receive tailored personal or electronic responses with links to primary data and impartial evaluation of the same. Some of these resources already exist.[51–54] We recommend that organizations identify and provide access to existing sources for quality prescriber and patient education materials, and direct funding to enhance and study these programs.

The perceived benefit of supplies, office food and social relief may be particularly difficult to overcome or replace. Our participants felt that academic centers have more flexible budgets and that without changes in healthcare structure and reimbursement, some offices may have difficulty giving up such substantial perks. These issues offer areas for further study.

Benefits of Meetings to Patients

Some participants talked specifically about PR products that directly benefited patients – educational materials, models, blood sugar diaries – and referred to the benefits of medication samples saying "We want to make people happy and you make people happy often when you give them a sample." Frequently they referred to work with indigent or underinsured populations and the ability to provide a medication that they knew the patient could not purchase while recognizing that the patient may not be able to afford the new medication in the long term. Others appreciated the convenience of offering samples for trial periods to determine dosing and side effects before the patient expended a co-pay, regardless of the patient's insurance coverage. Some suggested that patients expect samples, and in a medical system that already offers many roadblocks they do not want to add more.

Recommendations. Our focus group findings suggest that national societies should develop and study the impact of non-biased, tailorable patient support and educational materials that are freely available for download by providers or patients.

The issue of medication samples remains complex. Studies have shown that pharmaceutical samples are disproportionately not used by our most needy populations.[55] Development of prescription centers to manage pharmaceutical samples and insure that they are distributed to fulfill suitable prescriptions for those with financial need might help to decrease the impact of this disparity. Institutions should study whether these

centers improve prescribing, and whether the impact reaches private practice prescribers.

Social Contracts

Focus group participants identified what could be considered social manipulation or 'contracts' as another reason for meeting with PRs. They made comments such as "I know it's just the guy's job, and if I don't talk to him then he may lose it, so I talk to him." "You kind of feel like you are in a bit of a bind where you don't want to be totally rude." Some reported that their practice maintained PR relationships. Very few reported independently determining they would not meet with PRs if their practice allowed these interactions.

In some cases, particularly those with long-term relationships, participants reported enjoying the purely social aspects of PR interactions – "Sometimes we don't even talk about drugs, we just chat about the kids and it's good to have a relaxed and friendly lunch." Interestingly some participants pointed out that taking time to see PRs might mean making a patient wait, which could be considered breaking that 'contract.'

Recommendations. PR visits are part of a well-organized pharmaceutical marketing plan.[8,56–59] Our findings suggest that policies that restrict or eliminate access, or clearly define the parameters of interactions may allow prescribers to maintain social norms and limit PR influence. Such interventions should be studied. Involving prescribers of all training backgrounds in development and implementation of these policies may build on discipline-specific strengths and support local buy-in. Some academic and community-based practices have been successful in implementing policy changes related to PR interactions.[6,30,32–39,41] Successful programs should be publicized so that these experiences can serve as models for others. Personal stories, such as those shared by our focus group participants, were powerful in the groups and may support policy acceptance.

Comments on strategies and Policies for Interactions

While some participants reported policies to guide PR interactions, very few had been involved in developing them. Most adjusted to the norm of their practice group. Many different arrangements for PR visits were described including open access, scheduled office sessions for all staff with food, scheduled appointment times with prescribers only, after hours dinners, and social engagements. It seemed easy, and common, for prescribers to meet with PRs even in the presence of policies to limit such meetings.

No participants reported a specific strategy for evaluating PR materials or managing PR interactions, though many felt that over time they had developed a sense of how to do this. While some felt that trainees might benefit from targeted curricula, others said "I don't think residents need to be exposed to pharmaceutical reps to lean how to interact with them later in life because I think that it is pretty obvious and not hard to learn." Participants also noted that PRs reach them in various ways including email, fax, direct mail, cold-calling and social visits. The more impersonal of these were viewed as intrusive, though some appreciated the free CME.

A minority of participants practiced in settings that had policies against PR interactions. Some were mandated by the institution, met external regulatory requirements (JCAHO rules governing dispensing of drug samples), others simply met space and staffing needs. Some participants felt such restrictions were unfair to prescribers and patients; others welcomed the limitations. Several of the latter reported that initially they had been skeptical of policies, particularly prohibiting samples. However, in time they realized that prescribing patterns had been affected by the PRs and sample availability, and they now supported the policies restricting PR access. As this participant noted, "I was really hesitant about getting rid of the sample closet years ago, but now I think it was really, definitely the right thing because I would reach for the best nonsteroidal that was in there and at that point it was [brand name]. So I give a patient [brand name] thinking I did a good thing because he told me he didn't have any money, but often they would come back wanting [brand name] where I just could have given him Ibuprofen. …Once we didn't have it anymore, I realized that…"

One interesting and likely unintended consequence of having a policy was different enforcement with various clinic faculty and staff. In some cases policies applied only to MDs, thus PRs could still meet with NPs and health assistants. In one clinic PR access was not allowed to prescribers, but was allowed to the nurse who provided patient education on diabetes, who subsequently used PR products in her patient education sessions.

Some were bothered by the inconsistency between affiliate academic institutions restricting PRs in clinical settings, but accepting research or training funds. As this participant put it, "some of these universities have these big ideas about not letting any drug rep come into their surroundings. Yet, they receive a bazillion grants from drug companies to pay for all these other things that they do." Others commented on being able to interact with PRs at professional society meetings which were substantially underwritten by pharma, "I was so profoundly offended…We've gotten rid of the drug closet; we've gotten rid of the drug reps being here. The [journal name deleted] is publishing issues about bias introduced by the drug companies…and yet [its parent society meeting is] in its glory with everything being supported by these companies." Funding for societies also impacted our study enrollment as at least one national group we contacted openly refused our request to conduct focus groups at their meeting citing that might anger the representatives and jeopardize future pharma funding.

Recommendations. These comments support continued findings that many of our focus group participants do not believe that they need help managing PR interactions. We recommend that academic centers and societies take a leadership role by developing and studying the impact of comprehensive policies to regulate support and interactions. Importantly, the policy should apply to all members of the healthcare team including physicians, non-physician providers, administrators and office staff.

Influence on Prescribers by Training or Licensure

We identified a few differences in the attitudes and responses reported by participants with different training backgrounds. Some physicians seem to perceive PRs and related products as

deserved perks, and lamented the loss of extravagant practices such as tickets to major events or trips. Several non-physicians felt insulted by PRs who did not talk with them, as though they were not on equal professional footing with physician colleagues. One NP quote illustrates this "The drug reps come in, and this has been the problem for the last 9 1/2 years… They almost ignore you. I don't think they comprehend that nobody is telling me what I'm writing for that patient…I'm [writing the scripts] and they're totally blowing me off." One PharmD participant (PharmDs can prescribe in states such as New Mexico, and federal systems) raised an interesting variation on the social aspect of PR visits. He had trained many of the PRs and CECs who came to his clinic and thus welcomed seeing them for both social and professional reasons.

Recommendations. While most prescriber attitudes and responses were similar regardless of licensure, these examples suggest that differences between professional groups might warrant tailored curricula or intraprofessional training. We recommend multidisciplinary training to emphasize the varied professional skills of each member of the prescribing team so that individuals may learn from each other and build teams that have complementary skills towards common ends. Any such interventions should be studied.

Direct to Consumer Advertising (DTCA)

We specifically excluded questions related to DTCA from our focus group script; however the topic spontaneously arose in all focus groups. Participants overwhelmingly reported negative feelings towards direct to consumer advertising. They complained that companies were "flooding the airwaves" with misleading information that introduced conflict into the patient-provider relationship, and caused damage that required valuable clinical and telephone time to remedy.

Some raised the issue that DTCA may provide public education, encouraging patients to raise questions particularly regarding concerns that might be 'sensitive' or culturally taboo like depression or erectile dysfunction. A typical comment was "I have had some people come in in response to direct advertising seeking meds for conditions that they might not have otherwise, like erectile dysfunction…and depression has been a little bit de-stigmatized through the advertising." Others pointed out that many medications promoted through DTCA were for illnesses with a relatively low impact on morbidity and mortality, and that pharma money could be better spent on patient education for more critical health issues. Many participants worried that DTCA promoted false expectations for patients, "they think there's an instant cure. You know, people feel…we will give them a prescription for an instant cure. I think that TV, that those ads promote that."

Recommendations. Emphasizing the fact that DTCA and detailing are both part of a pharmaceutical company's marketing strategy, and noting the parallels between these may reinforce the negative impact of detailing. Integration of the analysis of DTCA into curricula for UME, GME and CME across disciplines may help prescribers identify the similarities between DTCA, which they openly criticize, and PR detailing. Such curricula should be studied.

Limitations

This study has several potential limitations. While focus groups were conducted using standard practice[60] some participants may have been uncomfortable. However presuming social desirability would promote not meeting with PRs, this bias should have yielded under-reporting which would further support our findings. Focus groups were conducted in varied geographic locations in clinical and educational settings, but findings may not be generalizable to all practices. Additionally participants may represent a self-selection bias. Prescribers with different training, but who worked in the same practice, were enrolled in the same groups in order to limit discomfort in talking across fields; however some reluctance may have remained. Additionally, all qualitative work can be biased by the coders. In order to reduce this bias we reviewed the literature, tested our themes and coding methods extensively and used two trained coders and an arbitrator as needed to perform final coding. Finally, the time lag to publication and emphasis of this topic in lay and professional press may have changed some opinions since our groups were held; however data regarding PR influence has been available for decades without apparently having this impact.

CONCLUSION

Prescribers of varied training backgrounds continue to meet with PRs despite substantive data regarding the influence of these interactions. Many of our primary care prescribers continue to believe that PR interactions improve patient care, and that they can adequately evaluate and filter the information presented to them by PRs. The perceived benefits of these interactions are deep and broad reaching. This was surprising to the authors who felt that popular and professional attention to this topic would have changed prescriber's attitudes and behaviors more. Our focus groups suggest that existing culture, lack of policy against such meetings, inconsistent implementation of restrictive policies or the broadening of the prescriber pool may be slowing this change. Future studies with larger samples of prescribers of broad professional training should evaluate these questions.

Our findings confirm and advance those of Prosser's study of UK physicians.[42] This is interesting as the structures, support and cultures of our healthcare systems are very different. Our work also broadens these findings to non-physician prescribers, and reports that practicing primary care prescribers have no specific training in managing PR interactions or evaluating PR materials, and in many cases believe they do not need it. Changing behavior may be particularly difficult under these circumstances, as many of our providers seem to be in denial or at Prochaska's precontemplative stage of change[61]. The findings reported here are also consistent with Chimonas' study which outlined the rationalizations that physicians use to reconcile the cognitive dissonance that develops from meeting with PRs,[23] and extends this to non-physician prescribers.

We agree that "it would be preferable were individual physicians [and all prescribers], mindful of the principles of medical professionalism, to reduce or eliminate interactions with drug representatives."[23] We also agree this is unlikely. We offer recommendations for policies and education to encourage

prescribers to reflect on these interactions, build skills and promote behavioral change. Ultimately, we may achieve the best success through the multiple foci of consistent implementation of clear policy, explicit curricula for trainees and for recertification, meeting provider needs with academic detailing and restructuring primary care reimbursement and support mechanisms to address administrative needs.

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APPENDIX: FOCUS GROUP QUESTIONS

1. How do you learn new information or maintain your knowledge of pharmaceuticals? By this I mean new drugs, new indications for established drugs, new side effect or risk information?
2. Please tell me about your exposure to drug marketing in the last week? Please be specific. Pharmaceutical representatives (called drug reps)? Journal advertising? DTC ads on TV/radio? Patient requests? Professional meetings? Educational presentations? Others? If there is little discussion probe - how about in the last month?
3. Overall do you feel that interactions with drug reps help or hurt your patient care? Can you give specific examples? Why? How?
4. What aspects of drug marketing, if any, do you find helpful, useful or informative? Why? How?
5. What aspects of drug marketing, if any, do you personally find difficult to deal with? Why? How?
6. Have you developed any particular strategies for dealing with drug marketing techniques that you have found helpful? Please be specific. How did you learn this technique? If they don't come up probe: drug reps, DTC advertising, how about here at the conference?
7. What sort of training or other support (including print or Web resources) would you need to better manage your interactions with drug reps or other pharmaceutical marketing?
8. Please tell me about any workplace policies that regulate your interactions with pharmaceutical representatives? What are those policies? Are they enforced? How? How do they impact your interactions with representatives? Patient care? Overall do you feel they are helpful? Harmful? What else might you suggest?
9. Any other information you would like to share on this topic?
10. What do you think about the fact that drug reps can obtain data about your own prescribing habits? Have you ever received personal information about your own prescribing from a pharmaceutical representative? What impact did that have on your interaction? On your prescribing?
11. When a choice exists, how do you decide to prescribe generic or prescription medication?
12. Now I'd like you to think about any personal information you may have received from a pharmacist or health plan about formulary medications, prescribing or generic medications. What impact did that have on your prescribing?
13. Can you talk about what happens when patients request specific medications based ads they have seen? What's a typical interaction like when this occurs? Do you feel these patients share any characteristics? (e.g., age, sex, SES, health status, conditions, etc.)
14. Please tell me about any HARD experiences you have had with a patient requesting a drug after seeing ads for it. What was most difficult?
15. Please tell me about any experiences you have had where a patient requested a drug because of an ad which led to better care for the patient.
16. How do you usually respond to a patient's request for medications that are not clinically appropriate? What influences how you respond to these sorts of requests?
17. Have you ever had training in how to respond to patient requests for specific advertised medications? What specific areas do you think such training should cover?
18. What other support (including Web or print resources) would be helpful to you?